Patient Demographic Information

Today's Date ______________________ **Signature of Patient** ______________________________________

Name: First______________________ **Middle**_____________ **Last**________________________________

Mailing Address ____

City_____________________________________ **State**____________ **Zip Code** _____________________

Primary Phone ____________________________ **Mobile Phone** __________________________________

❑ Check this box if you would like to receive text appointment reminders.

Please provide who your **Cell Provider is (needed for text reminders):** _______________

Primary Email ____

By providing my email address, I authorize my doctor and the admin staff to contact me via the email address provided.

Date of Birth ______________________ **Age** ______ Gender *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Spouse Data Is your spouse/significant other a patient in the clinic? ❑ Yes ❑ No

First Name_________________________ **Middle Initial**_____ **Last Name**________________________

Phone _____________________________ **Work Phone** ______________________________

Primary Care Physician____ **Phone**_______________________

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer Data **Name**____

Address ____

City_______________________________ **State**______ **Zip**______________

Job Title/Description ____

Emergency Contact **Name**______________________________________ **Phone**______________________

Relationship to you: _________________________

How did you hear about our office? ____